Highmark's P4V Strategy

West Virginia Health Innovation Collaborative

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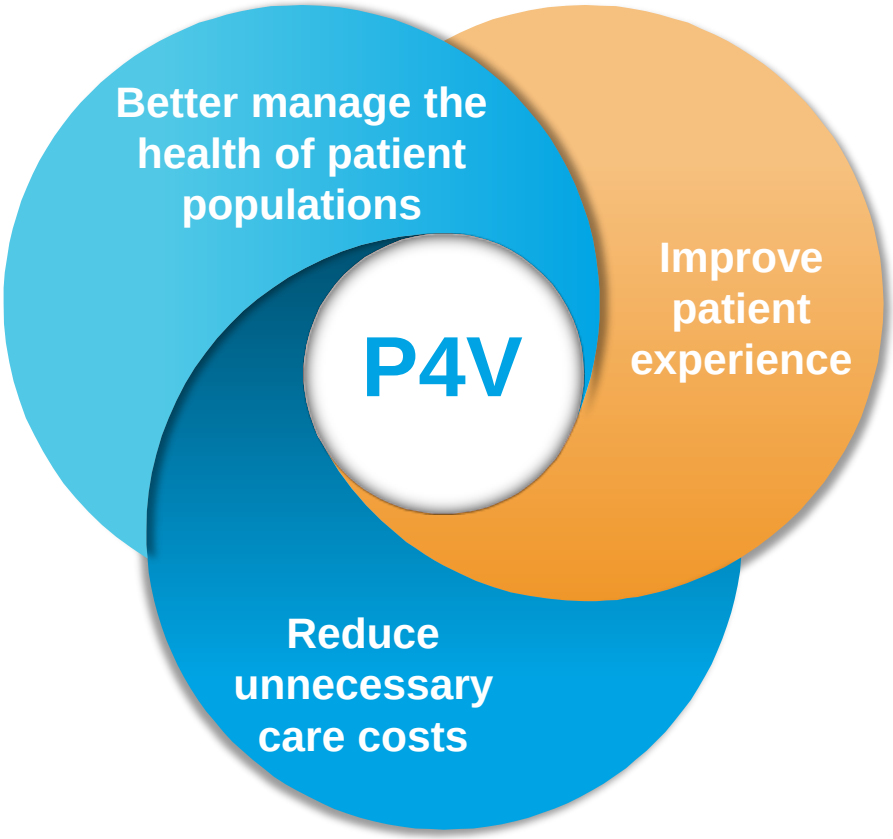
HIGHMARK HEALTH

Our current P4V programs have focused on hitting the “triple aim” of cost, quality, and patient experience



Current Highmark P4V strategy

- Focus on PCPs and hospitals to **effect cultural change** in local providers
- **Promote adoption at scale** by offering several programs based on provider capabilities and readiness for change
- Start with **upside-only incentives**, to provide a glide path for providers to eventually take on risk
- **Support provider success** through a comprehensive program that includes regular reporting and provider engagement

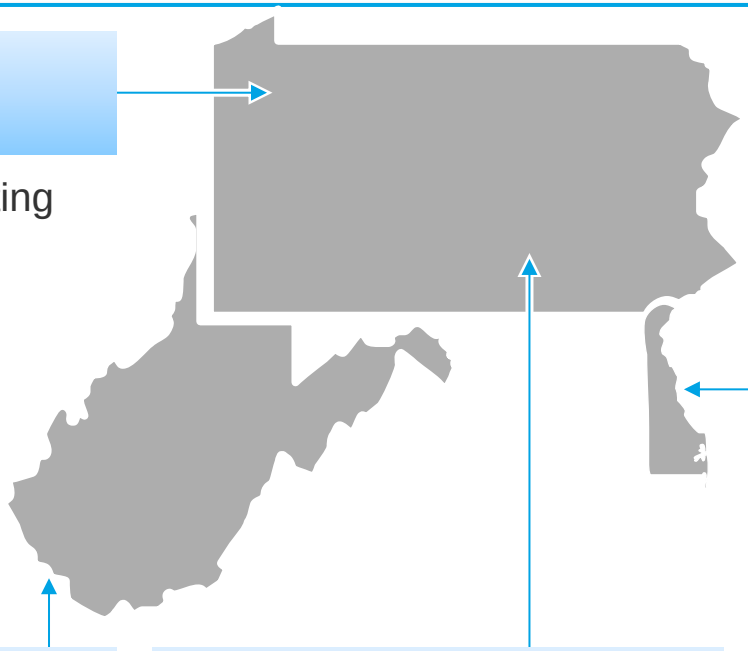
To date, our strategy has focused on trying to move every provider in our network towards value based care

We have achieved extensive scope and impact across our membership

More than 80% of members in Western and Central Pennsylvania now receive care within a Pay-for-Value program

Western Pennsylvania Quality Blue ACA/PCMH

- 450 practices representing 68 PCMH and 87 ACA entities
- 1,591practitioners
- 601,489 attributed members



Delaware PCMH Pilot

- 18 practices
- 51 practitioners
- 21,623 attributed members

West Virginia Quality Blue PCMH

- 88 practices representing 31 PCMH entities
- 399 practitioners
- 53,774 attributed members

Central Pennsylvania Quality Blue PCMH

- 335 practices representing 56 PCMH entities
- 2,007 practitioners
- 359,249 attributed members

Delaware Quality Blue ACO MedNet

- 63 practices
- 130 practitioners
- 52,849 attributed members

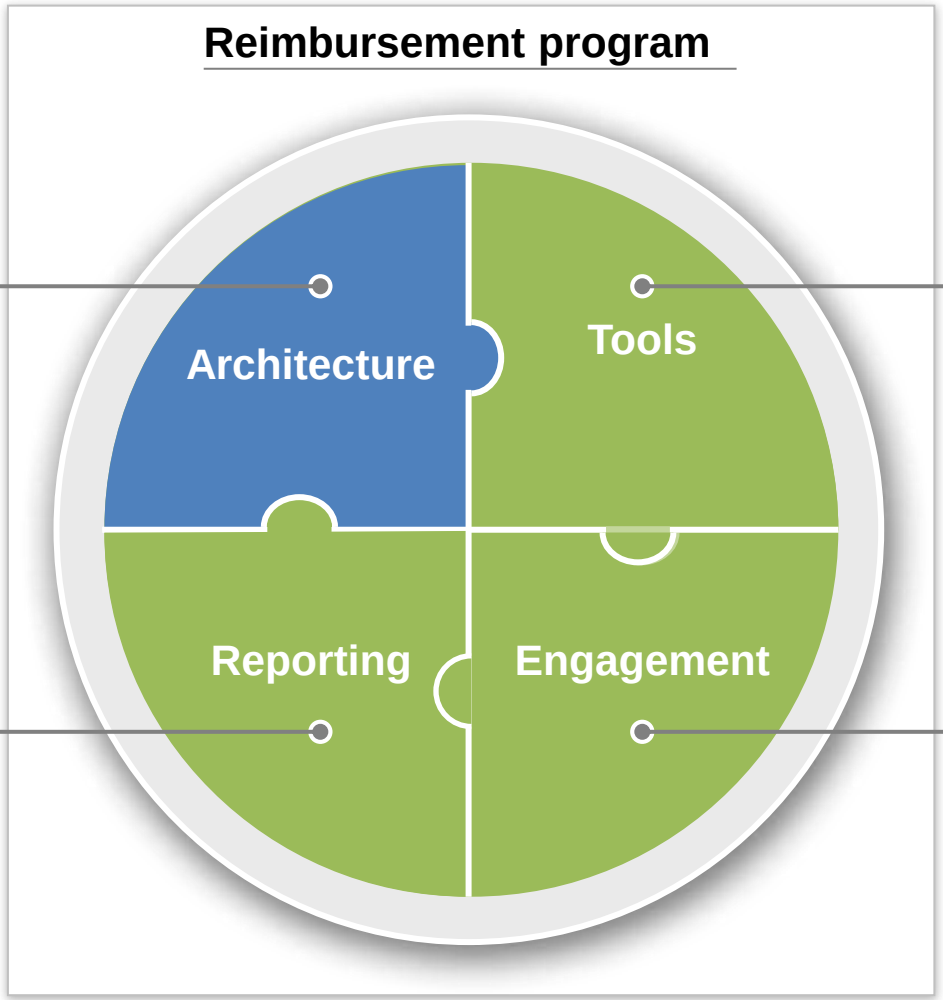
More than 1 million attributed members

How are we redesigning our reimbursement program?

Focus for today

Align metrics, scoring, and payment methodology across programs to drive quality and efficiency

Provide timely and actionable insights that can be integrated into provider workflows to enhance performance



Develop and deploy tools that combine clinical and claims data to provide differentiated value and customer experience

Leverage clinical transformation consultants to assist providers in streamlining workflows and optimize performance in programs

While the PCP programs have some strengths, there is a clear need to transform them for the future

What's working

- **Significant market penetration,** with 77% of members in P4V programs
- **Wide range of providers can participate** through multiple programs
- **Providers have multiple ways to earn incentive payments** (e.g., PCMH or Meaningful Use certification)
- **A variety of metric categories are represented**, including quality, cost, and care alignment

What's not working

- **Multiple programs create complexity**
- **No clear ROI** or evidence of cost / utilization improvement
- **Fee bump payment incentivizes overutilization**
- **Top performers can be punished** for not improving
- **Not all programs achieve a meaningful "share of wallet"**
- **Full incentive can be earned on quality alone**

Eight fundamental changes shape the new PCP program

1. **Launch one newly contracted program** across MA and Commercial with combined quality gate (Medicaid will phase in with Gateway transition)
2. Target up to **30% "share of wallet,"** to begin journey towards risk
3. **Transition to risk-adjusted care coordination fees with semi-annual lump-sum bonus** (both based on attribution)
4. Make full incentive **payment contingent upon satisfying three metric categories:** quality, cost, care alignment
5. **Use age-appropriate quality metrics**
6. **Introduce specialist referral patterns** as care alignment metric across regions
7. **Reward *either* performance improvement *or* maintenance of superior performance**
8. **Change to calendar year for all measurement and reporting** to align with MA STARS and Hospital Quality Blue

How the PCP incentive program would work

Pre-measurement fee determination

- Determine provider eligibility for prospective PMPM care coordination fee
- If eligible, begin prospective payment

Measurement period

Age group

<18 | 19-64 | 65+

Quality

- ~10 metrics across age groups, regardless of insurance type

Cost

- 3-4 metrics including total PMPM and utilization

Care Alignment

- Specialist referral patterns
- AHN admissions for relevant practices

Metrics will align with BDTC, CMS Stars, and state initiatives

Post-measurement payment determination

- Determine eligibility of practice, based on quality gate
- If quality gate met, pay lump sum for superior performance or improvement across 3 categories
- Based on quality gate, predetermine eligibility for prospective care coordination fee

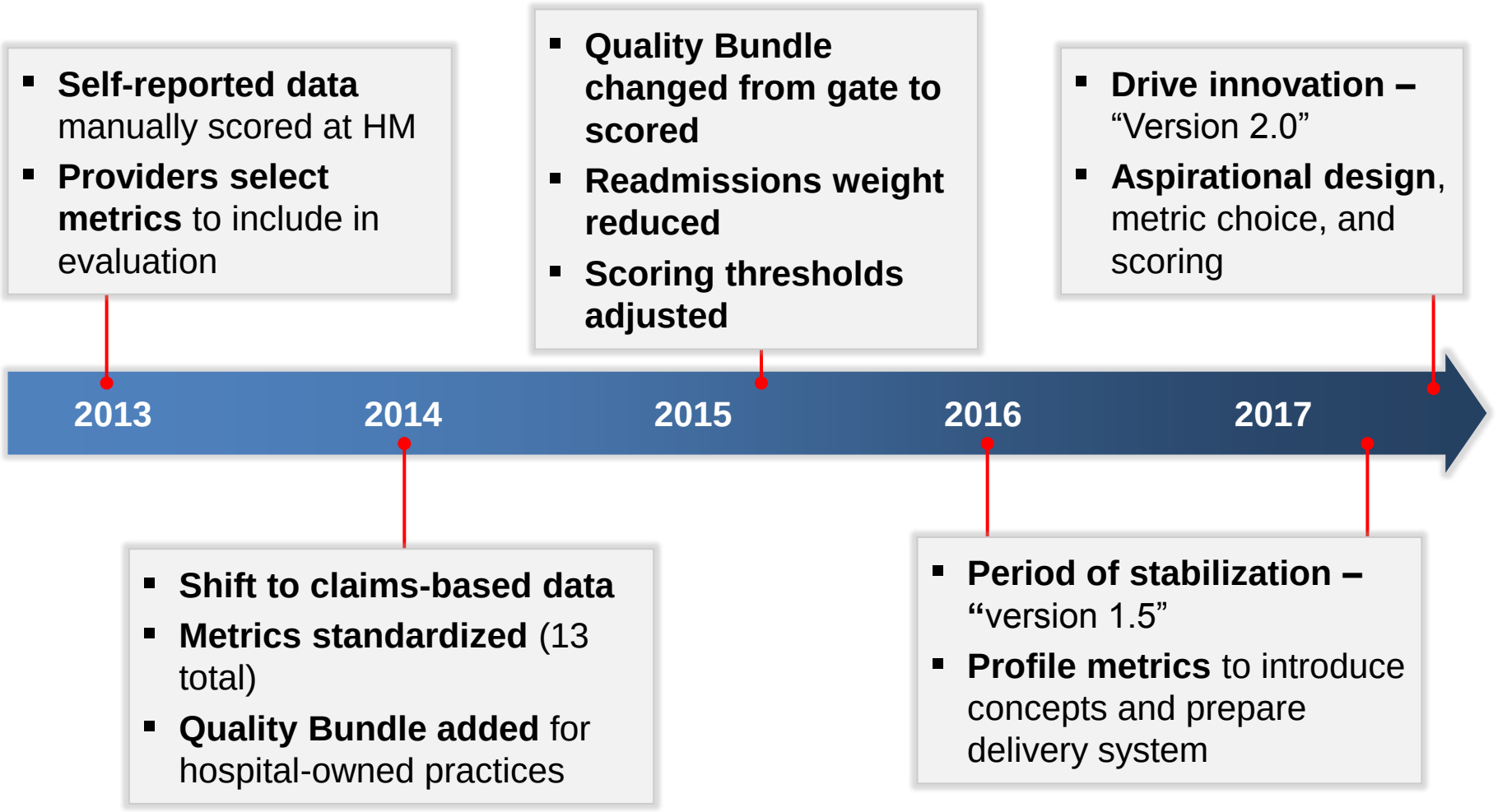
Measurement and reporting done on calendar year

What is distinctive about this new program?

Distinctive elements

1. Use of **proprietary specialist referral metric** based on enterprise analytics
2. **Performance-based care coordination fee** is shift away from fee bump
3. Total potential incentive represents **high "share of wallet"** which drives behavior change
4. **Single contracted program across products** to minimize provider complexity
5. Potential for **meaningful reward for *all* providers**

Hospital Quality Blue has undergone a journey and needs to evolve more



The recent redesign of the hospital program has led to a number of provider pain points that we are looking to address…

What's working

- **Inclusivity of program** with participants ranging from tertiary care to critical access hospitals
- **Emphasis on enterprise value drivers** with metrics such as readmissions, palliative care
- **More targeted and efficient support for providers** requiring lower resource investment

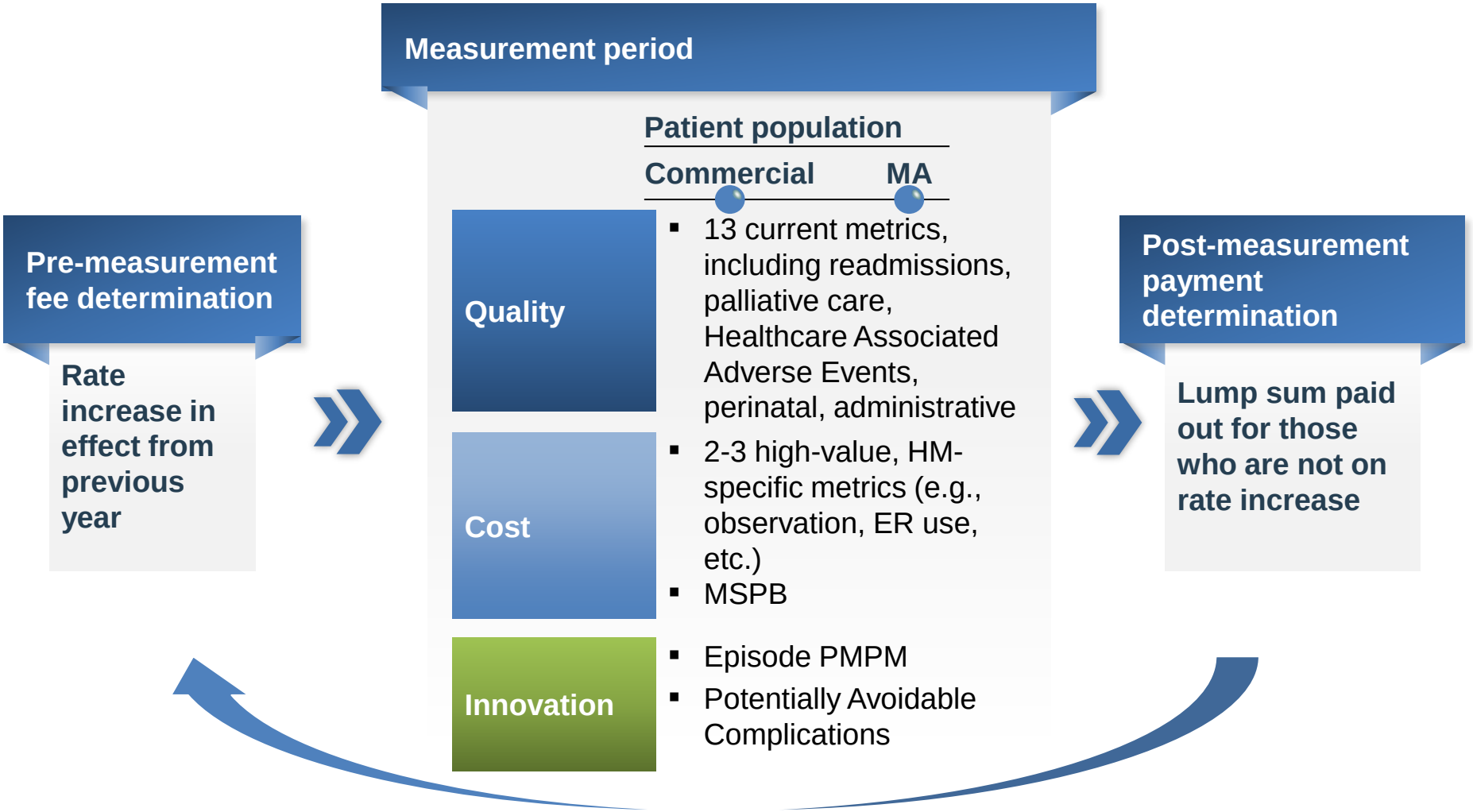
What's not working

- **Hospitals with low MA volume unfairly penalized** by the Quality Bundle
- **Inclusion of primary care metrics in a hospital program** led to penalty for providers
- **Speed to market led to inability to profile metrics,** resulting in difficult to achieve targets
- **Switch to claims-based reporting led to significant delays in data reporting**
- **Overlap of Quality Bundle with PCP programs that were on different timelines** caused conflicting reports and provider confusion

…with six fundamental changes to the Hospital program

1. **Remove quality bundle as currently represented in the program** (as STARS is addressed by physician incentive)
2. **Add 2-3 high-value, HM-specific cost/utilization metrics**
3. **Reassess scoring and weighting for all current metrics** to address previous issues
4. **Introduce high value episodes focusing on cost and quality through a new innovation category**
5. Offer incentive for **either performance improvement or attainment of superior performance**
6. Develop plan to **transition hospitals on lump sum payment to rate increase**

How the Hospital incentive program would work



What is distinctive about this new program?

Distinctive elements

- **Innovation track that creates focus among hospitals on select high value episodes,** and fosters sharing of best practices and care pathways
- **Episode-based measurement in a hospital program** to prepare the delivery system for change and provide a path toward greater risk sharing
- **High value utilization metrics to introduce new cost goals** that link with existing UM tools, e.g., use of NIA decision-support tools in the ER